Therapy Consent

Child’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Date of Birth\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

and give consent for them to receive therapy from the Kiki’s Children’s Clinic.

|  |  |  |
| --- | --- | --- |
| **Consent for therapy** | **√- Yes** | **X- No** |
|  |  |  |
| **Agreed location for treatment or screening** |  |  |
| Kiki’s Clinic |  |  |
| Home |  |  |
| Nursery |  |  |
| School |  |  |
| **Who must be present during treatment / screening?** |  |  |
| Parent |  |  |
| Guardian / Carer |  |  |
|  |  |  |
| I am happy for the child to be photographed and or videoed during therapy and for any images to be stored and potentially used for home programs etc. |  |  |
|  |  |  |
| I authorise the release of all necessary information to my primary care provider, referring doctor and or consultant. |  |  |
|  |  |  |
| I agree that information about therapy may be communicated by electronic means including e-mail. |  |  |

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to child:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_